GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 16, 2025

Simbarashe Chiduma
Open Arms Link
Suite 130
8161 Executive Court
Lansing, MI 48917

RE: License #: AM190409578
Investigation #: 2025A1029011
Open Arms Stoll

Dear Mr. Chiduma:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On January 15, 2025, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

If you desire technical assistance in addressing these issues, please feel free to contact me. Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AM190409578
Investigation #:	2025A1029011
Complaint Receipt Date:	12/13/2024
Investigation Initiation Date:	12/13/2024
Report Due Date:	02/11/2025
Licensee Name:	Open Arms Link
Licensee Address:	8161 Executive Court, Ste. 130, Lansing, MI 48917
Licensee Telephone #:	(517) 455-8300
Administrator:	Simbarashe Chiduma
Licensee Designee:	Simbarashe Chiduma
Name of Facility:	Open Arms Stoll
Facility Address:	3285 W Stoll Rd, Ste 130, Lansing, MI 48906
Facility Telephone #:	(517) 455-8300
Original Issuance Date:	08/25/2021
License Status:	REGULAR
Effective Date:	02/25/2024
Expiration Date:	02/24/2026
Capacity:	9
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive her Clozapine as prescribed because the script was not refilled at the pharmacy.	Yes

III. METHODOLOGY

12/13/2024	Special Investigation Intake 2025A1029011
12/13/2024	Special Investigation Initiated – Telephone to complainant by Eli DeLeon
01/07/2025	Contact - Document Received Email exchange with Corinne Holmes-Caudell RN
01/07/2025	Inspection Completed On-site – face to face with Open Arms Operations Manager Jason Zilka, direct care staff member / home manager Richard Kosger, and Resident A at Open Arms Stoll
01/08/2025	APS Referral made to Centralized Intake
01/10/2025	Contact – Document received - email from Centralized Intake – APS will not be investigating the concerns.
01/14/2025	Contact – Telephone call to licensee designee Simbarashe Chiduma. Sent email to Jason Zilka and Mr. Chiduma.
01/15/2025	Exit conference with licensee designee Simbarashe Chiduma.

ALLEGATION: Resident A did not receive her Clozapine as prescribed because the prescription was not refilled at the pharmacy.

INVESTIGATION:

On December 13, 2024 a complaint was received via Bureau of Community and Health Systems online complaint system with concerns Resident A did not receive her Clozapine as prescribed because the prescription was not refilled at the pharmacy.

On December 13, 2024 AFC licensing consultant Eli DeLeon contacted Complainant who confirmed Resident A had missed several days of her Clozaril medication as the pharmacy had attempted to contact Open Arms Stoll regarding the medication refill but these calls were not returned by anyone at this facility. Complainant reported house manager "Richard", last name unknown, had confirmed Resident A did not receive her

prescribed medication and clarified this medication may have been missed due to him going on vacation.

On January 7, 2025, I received an email from Community Mental Health (CMH) RN Corinne Holmes-Caudell who stated she was informed of these concerns on December 11, 2024 and entered the following contacts:

> *"December 11, 2024: This RN received a message this morning from Chelsea at Ascension Pharmacy, questioning client's Clozapine. Per Chelsea, she called the client's AFC Stoll Rd [Open Arms Stoll] just before Thanksgiving to ask about refilling the medication and current lab work, and did not receive return correspondence. The last time Clozapine was filled by Ascension Pharmacy was on 10.14.2024. This RN called Stoll Rd AFC [Open Arms Stoll] and spoke with manager Richard. Richard reviewed client's MAR, then stated she had not received the medication since 11.28.2024 as they did not have it at Stoll Rd AFC [Open Arms Stoll]. This RN requested and received a copy of client's MAR, confirming that client last received Clozapine on 11.28.2024. Richard stated he did not know that the pharmacy had called because he was off on vacation that week. This RN spoke with both Richard and Jason, Open Arms manager, and asked them to not give the Clozapine 300 mg at this point until psychiatrist gives orders regarding how to restart the medication. Both Richard and Jason verbalized understanding. This RN contacted psychiatrist to ask how medication should be restarted or given from this point. Awaiting return correspondence. This RN called Chelsea at Ascension back to inform her that we are awaiting further orders from psychiatrist regarding Clozapine. This RN received a voice message from Richard at Stoll Rd AFC [Open Arms Stoll] later this afternoon informing that client is being sent to the emergency room due to a fall and weakness. CM and psychiatrist notified.*
>
> *December 12, 2024: This RN received phone call from Dr. Schlacht this date who provided verbal order to discontinue Clozaril at this time due to client's recent increased weakness and fall, as well as client having not received medication for 2 weeks due to AFC not giving the medication. This RN discontinued the medication per verbal order, called Ascension Pharmacy and spoke with Chelsea and notified her of discontinued medication, and notified Stoll Rd AFC [Open Arms Stoll] managers Jason and Richard of discontinued medication, as well as case manager. Dr Schlacht requested AFC staff keep CMH informed of any decline in client's mental status or psychotic symptoms as well as physical decline. This RN informed both Stoll Rd [Open Arms Stoll] managers of her request."*

On January 7, 2025, I completed an unannounced on-site investigation at Open Arms Stoll and interviewed Open Arms Link Operations Manager, Jason Zilka. Mr. Zilka stated Resident A did not receive her Clozaril medication as prescribed after November 28, 2024 because it was not ordered, however she is no longer on this medication because it was discontinued. Mr. Zilka stated the medication cycle date is on the 9th of the month so he is aware the Clozaril did not get ordered because it was not received on November 9, 2024. Mr. Zilka stated Richard Kosger was responsible for ordering medications. Mr. Zilka stated now they are going through the medication cart two times per week to do a medication audit and if direct care staff members see they are low on a medication they are required to notify Mr. Kosger. Mr. Zilka stated Mr. Kosger took Resident A for lab work on December 12, 2024 before the decision was made to discontinue the medication. Mr. Zilka looked for documentation regarding contacts between the pharmacy and Mr. Kosger however he did not find any documentation prior to December 11, 2024.

During the on-site investigation I reviewed all Resident A's medication and medication administration record (MAR) and confirmed all her current medications were available in the home.

During the on-site, I reviewed the following documents pertaining to this incident:

1. *AFC Incident / Accident Report* written on December 12, 2024 from an incident date November 29, 2024 signed by Mr. Kosger.
    a. What happened: On November 29, 2024 house manager discovered Clozapine 100 mg tablet for [Resident A] was missing from her scheduled medications. Upon inquiry from the pharmacy a refill was voided pending her draw on November 26, 2024 by Ascension Pharmacy.
    b. Action taken by staff: Operations and management were notified about the missing medication for the resident. On December 12, 2024 the doctor discontinued the medication.
    c. Corrective measures: Staff training and corrective action for staff at Stolll Rd. was done by Operations and management to prevent future occurrences of this.
2. Resident A's MAR from November 2024 showing she was last administered Clozapine on November 28, 2024. November 29, 2024 and November 30, 2024 both have a notation that the medication was not available.
3. *Training Inservice Record Form* from December 16, 2024 to review the corrective action which was done with employees and encourage communication between shift and managers. Mr. Kosger signed this on December 16, 2024.
4. *Corrective Action Plan* which was completed on December 16, 2024 which was reviewed with all direct care staff members which included retraining all direct care staff members on medication procedures, communication protocols, manager responsibilities, and operations manager oversight.

On January 7, 2024, I interviewed direct care staff member whose role is home manager, Richard Kosger. Mr. Kosger stated when the medication cycle arrived,

Resident A's Clozapine medication was not delivered. Mr. Kosger stated Resident A moved in recently in October 2024 and he did not realize she needed to have labs done before another Clozaril could be ordered. Mr. Kosger stated after he realized this, Resident A was taken for her labs on December 13, 2024 and the medication was ordered. Mr. Kosger stated he noticed Resident A was out of the Clozapine on November 27, 2024 but she did not go for her labs until December 13, 2024. Mr. Kosger stated there was a delay "because of coordinating to see where the disconnect was" and direct care staff were trying to figure out where to take her for the lab work. Mr. Kosger stated he was also on vacation during this timeframe so that could have contributed to the delay in ordering the medication as well. Mr. Kosger stated from now on anytime direct care staff members notice a medication is running low, they are going to notify management as well. Mr. Kosger stated they also notified the case manager and they documented their calls with the RN however, he was unable to give dates of when these contacts occurred.

On January 7, 2025, I interviewed Resident A. Resident A stated she moved into Open Arms Stoll in October and really likes it. Resident A stated direct care staff members are responsible for her medications and she thinks they do a "nice job." Resident A stated she is concerned about her health because she had a urinary tract infection and was recently in the hospital due to weakness and a fall, but she did not believe that had anything to do with medications. Resident A stated she has a lot of doctors, nurses, and service providers who work to help her out and she appreciates all of them. Resident A was not aware of a time she did not receive her medications as prescribed but she was aware her doctor discontinued the Clozapine medication.

On January 15, 2025, I interviewed licensee designee Simbarashe Chiduma. Mr. Chiduma stated he felt that it was a "big mistake" from the manager, Richard Kosger. Mr. Chiduma stated the medications are supposed to be checked regularly so they should have known Resident A's Clozapine medication was not there. Mr. Chiduma stated manager Mr. Kosger quit his employment after the incident so Mr. Chiduma is working to find a way to ensure this does not happen again. Mr. Chiduma stated he is now getting an eMAR notification each time a resident medication is not administered within one hour of the schedule medication administration time. Mr. Chiduma stated this allows him to address the issue immediately.

There have been four previous special investigations for Open Arms Stoll in 2022 which also included a medication error.

1. 2022A0790006 March 30, 2022 - Former direct care staff member Elisha Richards stated a resident returned to the facility from rehabilitation with "little to no medication" and licensee designee also reported to Mr. Chiduma all prescribed medications did not arrive at the facility until three days after she returned. Based on these statements the resident did not receive all medications prescribed to her pursuant to label instructions.

2. 2022A0783040 April 20, 2022 - A residents medications were not given as prescribed because there were no refills remaining and staff members neglected to ensure the resident had refills on her medications.
3. 2022A0790019 June 1, 2022 - Resident was out of his Clozapine medication and direct care staff member and home manager Jada Moore has not taken the resident to get his blood drawn nor helped him receive new medication which resulted in the resident not receiving his prescribed medication Clozapine 50 mg tablet from 05-16-2022 through 06-01-2022 and no explanation was given. medication for this length of time
4. 2022A1029048 June 23, 2022 - Based on a review of Resident A's July 2022 written medication administration records, I determined there were several different medications on various dates in July 2022 that were not administered as prescribed including medications prescribed by a mental health provider.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the interviews with Mr. Kosger, Mr. Zilke, and licensee designee Mr. Chiduma there is evidence Resident A's Clozapine was not administered as prescribed. Based on my review of Resident A's MAR from November 2024 she was last administered Clozapine on November 28, 2024. According to the MAR, both November 29, 2024 and November 30, 2024, have a notation that Resident A's Clozapine was not available. Mr. Kosger did not have an explanation why there was a delay refilling the medication or why she did not have her labs drawn as required. Mr. Zilke provided a *Corrective Action Plan* completed on December 16, 2024 along with Medication Training verification was completed for all direct care staff members.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SIR # 2022A0790006 DATED MARCH 30, 2022, 2022A0783040 DATED APRIL 20, 2022, 2022A0790019 DATED JUNE 1, 2022, AND 2022A1029048 JUNE 23, 2022. CAP COMPLETED FOR ALL INVESTIGATIONS.]**

IV. RECOMMENDATION

An acceptable corrective action plan has been received, therefore; I recommend no change in the license status.

_____01/15/2025_____

Jennifer Browning
Licensing Consultant

Date

Approved By:

01/16/2025

_____

Dawn N. Timm
Area Manager

Date